Summary of Inspector General Activity

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During the fiscal year, 181 audit, review, and inspection reports were issued; 4 settlement agreements were completed; and 245 investigations were closed. These initiatives identified $256 million of actual and potential monetary benefits and resulted in 110 convictions and 235 administrative actions against third parties, VA employees, and benefit recipients.

Our audits, reviews, inspections, and investigations focused on VA's major program areas, as summarized in the following paragraphs.

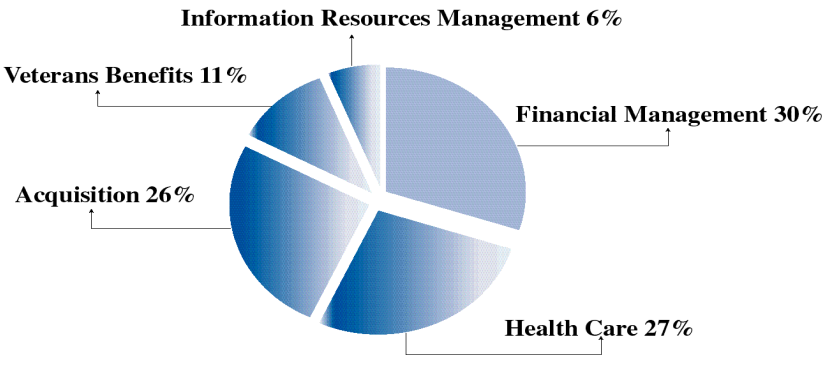
ACQUISITION PROGRAMS

Contractor Overcharges. VA recovered over $32 million during FY 1997 due to our identification of overcharges by Federal Supply Schedule (FSS) companies. These monetary recoveries were associated with 15 audit reports and settlement agreements. In one case, an FSS contractor paid VA $22.1 million, the largest settlement in VA's history under the FSS program.

Reviews of FSS Proposals. We completed 27 preaward reviews of FSS proposals from pharmaceutical and medical-surgical suppliers, with recommendations to reduce contract costs by a potential $67 million. These reviews assisted VA contracting officers in negotiating the best possible prices for VA.

Procurement Fraud. As the result of a joint investigation and contract review, a medical corporation that provided health examination equipment to VA acknowledged liability under the False Claims Act for submitting false and fraudulent billings. A $3 million judgment was entered against the corporation and the corporation agreed to permanent exclusion from Government contracting and programs. A joint investigation with two other Federal agencies resulted in an ambulance company owner being sentenced to over 5 years in prison and ordered to pay restitution of over $1 million for submitting inflated billings for ambulance services provided.

Percent of OIG activity during FY 1997 in each of VA's mission areas.



HEALTH CARE PROGRAMS

Resource Utilization. We reviewed four programs. Our

audit of VHA's initiative to implement mobile laboratory carts at VAMCs found that over $10 million earmarked for the initiative was used for other purposes or had been spent on equipment that was never used. In auditing VA's use of lithotripters, we found excess capacity and operating costs that could be reduced with management's actions to sell excess capacity, and to increase the use of contracts for community services. These actions are expected to result in a savings of over $2.7 million. Our review of use of Intergovernmental Personnel Act (IPA) assignments at one VAMC found IPAoverpayments of over $1 million annually due to inadequate controls. Our audit of VA's downsized inpatient substance abuse treatment program concluded that VHA had established adequate housing and social support resources for homeless veterans and other frequent users prior to the downsizing, but additional actions are needed to ensure these users have access to inpatient and outpatient care when needed.

Quality of Health Care.
Our assessment of VHA's compliance with quality standards for mammography services required by law concluded that VHA health care facilities are prepared to provide high quality services either in-house or through contract facilities. The review also concluded that actions were needed to: inform female patients of mammography service availability, increase mammography equipment use, and establish quality assurance programs. In our oversight review of VAMCs' implementation of External Peer Review Program (EPRP) requirements, we concluded that VAMCs used EPRP review results to develop better treatment methods, with action recommended for increased use of EPRP review results to strengthen the program.

Fee Basis Program. Our audit of the fee-basis program concluded that VHA had established controls to ensure payments for fee-basis treatment were appropriate, but additional actions were needed to reduce the rates paid and avoid duplicate or erroneous payments. In addition, $1.8 million could be reduced annually by establishing benchmarks for fees and formal contracts with fee providers.

Medical School Affiliations. Our summary report of 16 OIG audits on affiliation-related activities concluded that VHA management has made significant progress in addressing the issues we reviewed, including physician resource management, contractual relationships, and management information systems. We recommended continuing this momentum by pursuing renegotiation of affiliation agreements.

Patient Care Program Review. Our review of VHA's Living Will/Advance Directive program for patients' end-of-life decisions found that VHA clinical employees closely adhere to patients' desires regarding prolonging their lives in the final stages of illness. We recommended simplifying the paperwork involved and providing earlier counseling to make the process less intimidating to patients.

Patient Care Inspections. Six of our healthcare inspection reports concluded that the VAMCs involved needed to take actions to improve patient care. In one case, our inspection agreed with a clinical peer review which concluded that providers should have ordered medical tests and more closely monitored a patient who died. In another case, appropriate care was provided for a terminal patient, but an uninformed physician did not comply with the patient's request for heroic measurers and he died. In a third case, a patient's scheduled operation was cancelled twice by a surgeon without sufficient justification. In the fourth case, we concluded that lack of an anesthesiology quality management process provided an environment in which improper anesthesia treatment practices could occur

without being detected or corrected, and that inconsistent reporting of patient incidents in the operating room inhibited medical center managers' ability to identify equipment-related malfunctions, and correct them in a timely manner. In the other two cases, the alleged patient abuse or patient harm was not substantiated, but programmatic changes were needed at one of the VAMCs to improve the quality of care for their spinal cord injury unit; the other VAMC needed to improve its credentialing and privileging process.

Control of Drugs. During FY 1997, nine former VAMC employees were indicted or sentenced for theft or diversion of drugs. These individuals received sentences of 2 to 5 years probation and fines from $500 to $2,000.

VETERANS BENEFIT PROGRAMS

Delivery of Benefits and Service. We reviewed eight VBA areas: (1) compensation of VA beneficiaries who are also active military reservists, (2) compensation and pension (C&P) medical examination services, (3) C&P overpayments, (4) appointment and supervision of fiduciaries, (5) Fiduciary Beneficiary System (FBS) data, (6) administration of invested funds for the Servicemen Group Life Insurance (SGLI) and Veterans Group Life Insurance (VGLI) programs, (7) quality of decisions to waive the collection of C&P debts, and (8) the reliability of data in VBA's claims processing workload reporting system.

We estimated that active military reservists improperly received dual compensation payments of $21 million between fiscal years 1993 and 1995, with future dual payments totaling $8 million if corrections are not made.

Our followup review on C&P medical examinations found that the rate of incomplete examinations had not changed significantly since FY 1993, and that VHA and VBA coordinated efforts were needed to monitor and reduce the rate.

We concluded that C&P overpayments totaling over $30 million could be prevented by revising procedures to improve beneficiary reporting and increasing VA regional office (VARO) emphasis on overpayment prevention.

Our two reviews of VBA's fiduciary program concluded that appropriate fiduciaries are appointed, but both improved supervision of fiduciaries and establishment of appropriate FBS records are needed to reduce the risk of theft or misuse of beneficiaries' funds.

We found that the insurance company used by VBA to administer the SGLI and VGLI programs had deducted investment expenses from investment earnings without reporting it to VA, with the company subsequently agreeing to restore $3.8 million to invested assets and a $3.2 million reimbursement of lost income to the programs' reserves.

Our review of waiver decisions found a wide variance in decision results among VAROs and we questioned waivers that had been granted, valued at $2.9 million.

We found that additional actions are needed to improve the accuracy and reliability of VBA's workload reporting and performance measurement for claims processing.

Program Fraud. Investigations disclosed cases of pension, compensation, loan guaranty, and fiduciary fraud. An individual was sentenced to 9 months imprisonment for forging the signature of his deceased mother on U.S. Treasury checks in order to receive

pension benefits. Another individual received a 12-month prison sentence for receipt of compensation benefits to which she was not entitled, and another individual will waive future VA compensation benefits until the $144,000 he received for 100% unemployability, while working full time, is paid back. The owner of several real estate companies pleaded guilty to charges of conspiring to defraud VA and HUD by acquiring and selling property by deceptive means and agreed to property forfeitures valued at over $2.7 million. A county veterans' service officer was sentenced to over 3 years in prison and fined $10,000 for his involvement in schemes to defraud over 17 disabled veterans for whom he acted as fiduciary.

FINANCIAL MANAGEMENT

Consolidated Financial Statements

Our audit of VA's Consolidated Financial Statements (CFS) for FYs 1996 and 1995 concluded there has been significant progress to improve financial management during the last year, resulting in an unqualified opinion on the reasonableness of the year end balances. Six reportable internal control weaknesses were identified relating to real property, net receivables, unliquidated obligations, life insurance programs, security controls, and housing program accounting. We also completed nine other related reviews with VA management officials informed of areas where actions were needed to improve accounting operations. Another financial-related review identified duplicate payments totaling over $1 million. None of the conditions identified had a material financial effect on the FY1996 CFS.

Our Audit of VA's Consolidated Financial Statements for FYs 1996 and 1995 concluded there has been significant progress to improve financial management.

Income Verification

Our review of VHA's procedures to verify self-reported veteran income for means tests found that over 87 percent of the cases reviewed did not have signed means test documents. In addition, VHA lost the opportunity to collect over $3 million because veterans were erroneously identified as exempt from co-payments.

INFORMATION RESOURCES MANAGEMENT

*HR LINK$* We assessed VA's efforts to design, develop, and implement HR LINK$, VA's new human resources and payroll system, and concluded controls had been established to address the multifaceted details involved, and user involvement was significant. Additional actions to assist in ongoing implementation efforts were recommended.

IFCAP. An audit of VA's Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System (IFCAP) concluded that the system is performing as designed, with some exceptions, but that significant problems exist with security controls.

Telephone Access Systems. Our review of VA's use of Personal Identification Number (PIN) telephone access systems found that three VAMCs with PIN systems had reduced their long distance telephone costs by an average of 68 percent, with total annual savings of nearly $1 million. We concluded that telephone costs could be reduced by over $10 million annually if all VAMCs installed PIN systems.